BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANGELA MAE CLEMENS** **a.k.a. ANGELA MAE RAY** **a.k.a. ANGELA MAE CLEMENS-SEGAL** **7383 110 Avenue NW** **Byron, MN 55920** **Registered Nurse License No. 637347** Respondent	Case No. 2013-357 OAH No. 2012120463

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **May 24, 2013.**

IT IS SO ORDERED **May 24, 2013.**

Raymond Mallel

Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Leslie E. Brast, Deputy Attorney General, assisted by Lydia Zane, Senior Legal Analyst.

2. Angela Mae Clemens, a.k.a. Angela Mae Ray, a.k.a. Angela Mae Clemens-Segal, (Respondent) is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

3. On or about May 14, 2004, the Board of Registered Nursing issued Registered Nurse License No. 637347 to Angela Mae Clemens. The Registered Nurse License was in full force and effect at all times relevant to the charges contained herein and will expire on May 31, 2014, unless renewed.

JURISDICTION

4. Accusation No. 2013-357 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 2, 2012. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2013-357 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 2013-357. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2013-357, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. 637347 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue

an order accepting the surrender of her Registered Nurse License without further process.

CONTINGENCY

10. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 637347, issued to Respondent Angela Mae Clemens, a.k.a. Angela Mae Ray, a.k.a. Angela Mae Clemens-Segal, is surrendered and accepted by the Board of Registered Nursing.

1. The surrender of Respondent's Registered Nurse License and the acceptance of the

surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board of Registered Nursing.

2. Respondent shall lose all rights and privileges as a Registered Nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2013-357 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If and when Respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $7,587.50. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 2013-357 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

7. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated

Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 3/13/13

ANGELA MAE CLEMENS
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: 3/14/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General

LESLIE E. BRAST
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 2013-357

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Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant), brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about May 14, 2004, the Board issued Registered Nurse License Number 637347 to Angela Mae Clemens, a.k.a. Angela Mae Ray, a.k.a. Angela Mae Clemens-Segal, (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 492 of the Code provides in pertinent part, that, notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code, or successful completion of an alcohol and drug problem assessment program under Article 5 (commencing with Section 23249.50) of Chapter 12 of Division 11 of the Vehicle Code, shall not prohibit any agency established under Division 2 (commencing with Section 500) of this code, or any initiative act referred to in that division, from taking disciplinary action against a licensee or from denying a license for professional misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest.

STATUTORY PROVISIONS

7. Section 2761 of the Code states in relevant part that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional

licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it.

(e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license.

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

. . .

8. Code section 2762 states in pertinent part that in addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in "Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possessions of, or falsification of a record pertaining to, the substances described in subdivision

(a) of this section, in which event the record of conviction is conclusive evidence thereof.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

9. Section 490 of the Code provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. An action that a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code.

REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1444, states in pertinent part that a conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

11. Code section 4021 states that a "'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

12. Code section 4022 sets forth that a "'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

13. Ketorlac, also referred to as Toradol[1], is a non-steroidal anti-inflammatory drug (NSAID) and a dangerous drug as designated by Code section 4022.

14. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subsection (L) and a dangerous drug within the meaning of Code section 4022. Morphine is a powerful opiate analgesic medication.

COST RECOVERY

15. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. This does not preclude the Board from including cost recovery in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Out of State Discipline)
(Bus. & Prof. Code section 2761, subd. (a)(4))

16. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), in that Respondent's Iowa nursing license was disciplined by the Iowa Board of Nursing (Iowa Board), as follows:

a. On or about July 11, 2006, the Iowa Board entered a Combined Statement of Charges, Settlement Agreement, and Final Order (Order) indefinitely suspending Respondent's license to practice nursing in the State of Iowa pending receipt of a chemical dependency evaluation from a provider approved by the Iowa Board. Subject to the agreement, the suspension was to continue until such time as Respondent could verify 12 continuous months of sobriety. Upon fulfillment of the Iowa Board's provisions, Respondent's license would then be placed on probation for a period of 12 months subject to terms and conditions including verified attendance at structured recovery group meetings and agreement not to use alcohol or illicit drugs

[1] Commonly misspelled as "Toridal."

or deviate from the therapeutic use of prescribed medications. Respondent agreed to comply with the requirements set forth in the Iowa Board's Order with the understanding that failure to do so would subject her license to further action.

b. The circumstances underlying the Iowa Board's imposition of discipline against Respondent's Iowa nursing license are that, on or about January 14, 2006, while working at an Iowa Hospital as a traveling nurse, Respondent tested positive for Cocaine, THC, and Benzodiazepines.

SECOND CAUSE FOR DISCIPLINE
(Substantially Related Conviction)
(Bus. & Prof. Code section 2761, subd. (f) and/or 490)

17. Respondent is subject to disciplinary action under Code sections 2761(f) and/or 490 in that she was convicted of a crime or crimes substantially related to the practice of nursing, as follows:

a. On or about April 26, 2006, in Sonoma County Superior Court, Case No. SCR-484973, Respondent was convicted of having violated Business and Professions Code section 4060 for knowingly and unlawfully possessing Toradol, a controlled substance, without a prescription. On or about December 4, 2007, the conviction was dismissed pursuant to Penal Code section 1203.4.

b. On or about November 29, 2011, in Olmstead District Court, State of Minnesota, Case No. 55-CR-11-5123, Respondent was convicted of having violated Minnesota Statute 169A.20.1(1), for operating a motor vehicle while under the influence of alcohol.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct –Possess/Obtain Controlled Substance/Dangerous Drug)
(Bus. & Prof. Code section 2761, subd. (a), and/or 2762, subd. (a))

18. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code sections 2761(a) and/or 2762 (a), in that she illegally obtained and/or possessed a controlled substance or dangerous drug, as described in paragraph 17(a), above.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - False, Grossly Incorrect, Inconsistent, or Unintelligible Charting)
(Bus. & Prof. Code section 2761, subd. (a) and/or 2762, subd. (e))

19. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code sections 2761(a) and/or 2762 (e) in that, in or around July 2010, while employed as a Clinical Nurse II in the Telemetry Department of Santa Barbara Cottage Hospital, Cottage Health Care Systems (Cottage Hospital), in Santa Barbara, California, Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in patient medical records pertaining to controlled substances or dangerous drugs, as follows:

a. **Patient #1: Medical Record No. 665886 (MR 665886)**

Patient #1 had a physician's order for Morphine IV, 1-2 mg every 2 hours as needed for pain. A review conducted by Cottage Hospital staff of MR 665886 uncovered false, grossly incorrect, grossly inconsistent, or unintelligible entries in the patient's medical records as set forth below:

(1.) On or about July 23, 2010, at 2148 hours, Respondent removed 5 mg of Morphine from Cottage Hospital's medication dispensing system (Accudose) for Patient #1. There was no pain score assessed for the patient and no documentation that the medication was administered. At 2159 hours, the record indicated that Respondent wasted 5 mg as a dropped vial. Respondent did not remove any other medication for administration for the patient. No pain score was assessed.

(2.) On or about July 23, 2010, at 2321 hours, Respondent removed 5 mg of Morphine from Accudose. The patient's pain score was assessed as 4/10 with 1 mg of Morphine given at 2330 hours. As recorded, the entire 5 mg dosage was wasted by Respondent as refused by the patient at 2321 hours.

(3.) On or about July 24, 2010, at 0033 hours, Respondent removed 5 mg of Morphine from Accudose. 1 mg of the Morphine was documented as given at 0040 hours. Respondent wasted 3 mg of Morphine at 0034 hours leaving 1 mg of Morphine unaccounted for. The Morphine was given 1 hour and 10 minutes from the last dose instead of 2 hours as ordered

by the Physician. The patient's pain score of 4/10 was documented after Respondent withdrew the Morphine from Accudose. Cottage Hospital staff noted that Respondent had been counseled on this issue previously in November 2009.

(4.) On or about July 24, 2010, at 0140 hours, Respondent removed 5 mg of Morphine from Accudose. 1 mg of the Morphine was given at 0145 hours. The patient's pain assessment score was 4/10 at 0200 hours. Cottage Hospital staff noted that the Morphine had been given 1 hour and 5 minutes from the last dose instead of the ordered 2 hours by the Physician.

(5.) On or about July 24, 2010, at 0450 hours, Respondent removed 5 mg of Morphine from Accudose. 1 mg of the Morphine was documented as given at 0500 hours. Respondent wasted 4 mg of Morphine at 0450 hours. The patient's pain score of 4/10 was documented at 0500 hours, after Respondent withdrew the Morphine from Accudose. Cottage Hospital staff noted that Respondent had been counseled on this issue previously in November 2009.

(6.) On or about July 24, 2010, at 0628 hours, Respondent removed 5 mg of Morphine from Accudose. 1 mg of the Morphine was documented as given at 0630 hours. Respondent wasted 4 mg of Morphine at 0629 hours. No pain score was assessed. The medication was given 1 hour and 30 minutes from the last dose instead of 2 hours as ordered by the Physician.

b. **Patient #2: Medical Record No. 915864 (MR 915864)**

Patient #2 had a physician's order for Morphine IV, 1-2 mg every 3 hours as needed for severe breakthrough pain. A review conducted by Cottage Hospital staff of MR 915864 uncovered false, grossly incorrect, grossly inconsistent, or unintelligible entries in the patient's medical records as set forth below:

(1.) On or about July 22, 2010, at 1949 hours, Respondent removed 5 mg of Morphine from Accudose for Patient #2. Morphine 2 mg was documented as given at 1950 hours. Respondent wasted 3 mg of Morphine at 1950 hours. However, Respondent also documented in the patient's pain assessment sheet that she gave the patient 1 mg at 2000 hours

which contradicts what she documented in the patient's medical record and which leaves 1 mg of Morphine unaccounted for.

(2.) On or about July 22, 2010, at 2055 hours, Respondent removed 5 mg of Morphine from Accudose. The patient's pain score was assessed at 4/10. Morphine 1 mg was documented as given at 2100 hours with 4 mg of Morphine wasted at 2100 hours. The Morphine was given 1 hour and 10 minutes from the last dose instead of every 3 hours as ordered by the physician.

(3.) On or about July 22, 2010, the physician's order for Patient #2 changed to "1 time order for 2 mg IVP @2215." At 2217 hours, Respondent removed 5 mg of Morphine from Accudose for the patient. Morphine 2 mg was documented as given at 2220 hours. Respondent wasted 3 mg of Morphine at 2218 hours. On or about July 22, 2010, the physician's order changed to "1 time order for 2 mg IVP @2250." At 2249 hours, Respondent removed 5 mg of Morphine from Accudose. Morphine 2 mg was documented as given at 2240 hours with 3 mg wastage of Morphine at 2250 hours. Cottage Hospital Staff noted that Respondent called for another dosage of medication 50 minutes from the time that the previous dosage was charted as given. Respondent documented administration of the medication at 2240 hours, 10 minutes prior to the time that the physician ordered it to be given.

(4.) On or about July 22, 2010, the physician's order changed to "1 time order for 2 mg IVP @2305." At 2259 hours, Respondent removed 5 mg of Morphine from Accudose and documented the medication as given at 2255 hours. Respondent wasted 3 mg of Morphine at 2302 hours. Cottage Hospital Staff noted that Respondent again called for another dose of medication, this time 15 minutes from the time that the previous dosage was charted as given. Further, Respondent charted that she gave the medication dosage 10 minutes prior to the time that the physician ordered it to be given.

(5.) On or about July 23, 2010, the physician's order was for 1-2 mg of Morphine every 3 hours as needed for severe break-through pain. At 0012 hours, Respondent removed 5 mg of Morphine from Accudose. The patient's pain score was documented as 5/10 at 0000 hours. Respondent wasted 3 mg of Morphine at 0013 hours and then wasted 2 mg of Morphine at 0015

hours. The patient was asleep at 0000 hours and refused the medication. Cottage Hospital staff noted that Respondent had been counseled on this issue previously in November 2009.

(6.) On or about July 23, 2010, at 0118 hours, Respondent removed 5 mg of Morphine from Accudose. She documented the patient's pain score as 5/10 at 0100 hours. Respondent wasted 4 mg of Morphine at 0119 hours and documented that 1 mg of Morphine was given to the patient at 0120 hours. On or about July 23, 2010, at 0249 hours, Respondent removed 5 mg of Morphine from Accudose. She documented the patient's pain score as 5/10 at 0300 hours. Respondent wasted 4 mg of Morphine at 0252, leaving 1 mg of Morphine uncharted as given and thus unaccounted for. Further, the patient's pain score was documented after she removed the medication from Accudose. Cottage Hospital Staff noted that Respondent had been counseled on this issue previously.

(7.) On or about July 23, 2010, at 0654 hours, Respondent removed 5 mg of Morphine from Accudose. Respondent wasted 4 mg of Morphine at 0650 hours and documented that 1 mg of Morphine was given to the patient at 0650 hours, thus charting that she gave the dose prior to removing it from Accudose. There was no pain score assessed.

FIFTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct/Dishonesty)
(Bus. & Prof. Code section 2761, subd. (a) and/or 2761 subd. (d))

20. Respondent is subject to disciplinary action under Code section 2761(a) and/or 2761(d), for unprofessional conduct and/or dishonesty in that, on or about June 15, 2011, during the course of a Board investigation of the Cottage Hospital complaint, Respondent represented to the Board's investigator that she had never been arrested or convicted of a misdemeanor or felony. In fact, Respondent was convicted on or about April 26, 2006, of having violated Business and Professions Code section 4060 as set forth in paragraph 17(a), above.

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SIXTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Out of State Discipline)
(Bus. & Prof. Code section 2761, subd. (a)(4))

21. Respondent is subject to disciplinary action under Code section 2761 (a)(4) in that, on or about February 2, 2012, in the disciplinary action entitled *In the Matter of Angela M. Clemens, R.N., License No. 156408-2,* before the Minnesota Board of Nursing (Minnesota Board), the Minnesota Board entered a Stipulation and Consent Order denying Respondent's Application for Reregistration. Her existing license to practice professional nursing in the State of Minnesota was suspended subject to her completion of sobriety monitoring, self-reporting, reporting from her employer, reporting from a mental health treatment professional, reporting of prescribed mood-altering chemicals, and a chemical dependency evaluation. Respondent stipulated to the following facts set forth in the Stipulation and Consent Order:

a. On or about August 10, 2010, Respondent submitted an Application for Reregistration of her license to practice professional nursing in the State of Minnesota.

b. On the Minnesota Board's application, Respondent stated that in 2006, she was convicted of possession of a controlled substance; however, the conviction had been overturned and expunged. Respondent also stated that she had completed a drug rehabilitation program in June 2006 and claimed abstinence from all mood-altering substances since September 2006.

c. On the Minnesota Board's application, Respondent answered "no" to questions regarding past or pending disciplinary action against her nursing licenses in other jurisdictions. On or about August, 11, 2010, the Minnesota Board obtained a copy of the Iowa Board's Combined Statement of Charges, Settlement Agreement, and Final Order issued on July 11, 2006, suspending Respondent's license to practice nursing in the State of Iowa.

d. In May 2006, Respondent entered a chemical dependency treatment program in Minnesota. Respondent was diagnosed as dependant on methamphetamine, cocaine, and opioids. Respondent completed the treatment and aftercare program. Respondent reported a relapse in September 2006 on alcohol during her time in the program.

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e. Respondent worked in several health care facilities in California from January 2008 to August 2010. Respondent's employment as a nurse was terminated following an investigation of missing morphine.

f. On or about July 13, 2011, Respondent was arrested in Minnesota and charged with driving while impaired by the use of alcohol. On or about November 29, 2011, Respondent was convicted by her plea of guilty to misdemeanor "driving while under the influence" in Rochester, Minnesota.

h. In September and October 2011, Respondent participated in an outpatient chemical dependency treatment program. In October 2011, Respondent was hospitalized for psychiatric care on two occasions.

i. In November 2011, respondent completed an inpatient chemical dependency treatment program. Respondent's diagnoses included opioid dependence and polysubstance dependence.

j. On or about January 11, 2012, Respondent admitted to Minnesota Board staff that she had provided false information on her Application for Reregistration and during the subsequent investigation. Respondent acknowledged that she had continued to abuse opiods, alcohol and illegal substances after completing chemical dependency treatment and aftercare in 2006 and 2007. She denied theft of medications from her employers since 2006. Respondent stated that she had not abused opiods since December 2010 and gave the Minnesota Board a sobriety date of September 27, 2011.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Dangerous or Injurious Use of Alcohol)
(Bus. & Prof. Code section 2761, subd. (a), and/or 2762, subd. (b))

22. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code sections 2761(a) and/or 2762 (b), in that she used alcohol to an extent or in a manner dangerous or injurious to herself, or any other person, as set forth in paragraphs 17(b) and 21(f), above.

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EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct –Drug/Alcohol-Related Crime)
(Bus. & Prof. Code section 2761, subd. (a), and/or 2762, subd. (c))

23. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code sections 2761(a) and/or 2762 (c), in that she was convicted of a crime or crimes involving a controlled substance, dangerous drug, or alcoholic beverage, as set forth in paragraphs 17 and 21, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 637347, issued to Angela Mae Clemens, a.k.a. Angela Mae Ray, a.k.a. Angela Mae Clemens-Segal;

2. Ordering Angela Mae Clemens, a.k.a. Angela Mae Ray, a.k.a. Angela Mae Clemens-Segal, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: November 2, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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